STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155139	A. BUILDING 00 B. WING	01/24/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH WOODS VILLAGE	2233 W JEFFERSON ST KOKOMO, IN 46901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for a Recertification and State Licensure Survey. This visit was in conjunction with the investigation of Complaints IN00123040 and IN00122596. Survey dates: January 14, 15, 16, 17, 18, 22, 23, and 24, 2013 Facility number: 000064 Provider number: 155139 AIM number: 100288770 Survey team: Michelle Carter, RN, TC Tammy Alley, RN (January 14, 15, 16, 18, 22, 23, and 24, 2013) Rita Mullen, RN Census bed type: SNF: 17 SNF/NF: 143 Total: 160 Census payor type: Medicare: 36 Medicaid: 94 Other: 30 Total: 160 These deficiencies reflect state findings cited in accordance with 410	F0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	IAC 16.2. Qualtity Review completed by Tammy Alley RN on 1/30/2013.			

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F0156 SS=B	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes:			

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	A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the			

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	individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.			
	Based on observation and interview, the facility failed to date the Medicare letters that contained information regarding the date of benefit exhaustion. This affected 2 of 3 residents reviewed for Medicare denial of payment notification. (Residents #32 and #41.) Findings include: On 1/17/13 at 1:00 P.M., letters of Medicare benefit exhaustion were reviewed for Resident's #32 and #41. Resident #32's discharge date was 9/10/12. A nursing note, dated, 9/10/12, at 10:55 A.M., indicated, "Resident signed MCR (Medicare) cut letter as he is discharging to home per his choice on this date." The letter was dated 9/10/12. Resident	F0156	The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and respectfully requests Desk Review in lieu of a Post Survey Review on or after February 22, 2013. **F156 Notice of Rights, Rules, Services, Charges** It is the practice of this provider to ensure residents are inform the resident both orally and in writing in a language that the resident	02/22/2013

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	#32 signed the letter and did not date it. During an interview with the BOM (Business office manager) and the SSD (Social Services director) on 1/17/13 at 1:41 P.M., they indicated the date of exhausted benefits was discussed during care plan meetings. However, this info was not documented. Resident #41's discharge date was 12/21/12. The Medicare Cut letter was signed and dated by his POA (power of attorney) on 12/20/12. Resident #41's admission date was 11/26/12. During an interview with the SSD and BOM, on 1/17/13 at 1:50 P.M., they indicated Resident #41 and the POA were aware of the benefits exhaustion date. However, documentation related to when the resident or POA was aware of the date of benefit exhaustion, was not provided. 3.1-4(a)		understands of his or her rights and all rules and regulation governing resident conduct and responsibilities during the stay in the facility. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** · The residents #32 and #41 were given notice, proper documentation will be recorded accurately to date of receipt of notification. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken** · Residents that require notification of services have the potential to be affected by the alleged deficient practice. · Audit of Resident records to ensure residents received notification of benefit exhaust. · Social Services (SS) and Business office Manager (BOM) were re-educated on education by the Staff Development Coordinator (SDC) and Executive Director on 1-30-2013. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur.** · SS and BOM were re-educated on 1-30-2013by SDC and Executive Director on proper notification and documentation of the notification. · Notification will be documented by SS when	

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			notified during Care Plan meeting or within 48 hours, BOM will monitor with a notification log of notification dates and Last Covered Day (LCD) to ensure timely notification. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place** · The CQI tool "Notice of Non Coverage Letters" will be utilized by the Interdisciplinary Team weekly for four weeks, monthly for three months and quarterly thereafter for at least 6 months. · The Executive Director (ED) /or Designee is responsible to monitor for compliance · The CQI team reviews the audits monthly and action plans are developed as needed if threshold of 90% is not met to ensure continual compliance **Compliance date: February 22, 2013**	

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F0282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, interview, and record review, the facility failed to ensure lab orders were completed for 1 of 10 residents reviewed for unnecessary medications in a sample of 10. (Resident # 62) Findings include: The record for Resident # 62 was reviewed on 1/18/13 at 9:24 a.m. Current diagnoses included, but were not limited to, hypothyroidism and chronic headache. Physician orders for January 2013 indicated an order for a T4 (lab test to evaluate thyroid function) laboratory test to be drawn every 6 months. Original date of the order was 9/30/08. The record lacked T4 results for the past year. During interview on 1/18/13 at 1 p.m., LPN # 1 indicated she was unable to locate a T 4 level and she did not	F0282	**F282 Services by Qualified Persons/Per Care Plan** It is the practice of this facility to provide or arrange services and these services must be provided by qualified persons in accordance with each resident's written plan of care. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** · Resident #62 physician was notified and new orders obtained, Laboratory orders where placed appropriately on schedule of Labs. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken** · All residents residing in the facility have the potential to be affected by the alleged deficient practice. · Residents lab orders were audited to ensure no other labs were missed by Director of Nursing/ Assistant Director of Nursing and/or Unit Managers · Licensed Nursing Staff were re-educated on ensuring laboratory(lab) orders are completed with a post test administered to evaluate retention	02/22/2013

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	have the laboratory order on her tracking form and the lab had not been drawing the T4 level. 3.1-35(g)(2)		of education by SDC/DNS/Designee on 1-30-2013. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur** · Residents lab orders were audited to ensure no other labs were missed by Director of Nursing/ Assistant Director of Nursing and/or Unit Managers. · Licensed Nursing Staff were re-educated on ensuring Lab orders are completed with a post test administered to evaluate retention of education by SDC/DNS/Designee on 1-30-2013. · Interdisciplinary Team reviews all laboratory orders during morning meetings to ensure labs are completed as ordered. During the weekend, the weekend nurse manager will monitor lab orders for completeness as ordered. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place** · The CQI tool "Laboratory Services" will be utilized and completed weekly x4, Monthly x 2, and then quarterly thereafter for at least 6 months by DNS/ADNS/Unit Managers · The nurse managers and charge nurses in the facility will be responsible to monitor for compliance. · The CQI committee reviews the audits	

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			monthly and action plans developed as needed to ensure compliance if threshold of 90% not met. · Non-compliance with facility policy and procedure may result in disciplinary action up to and including termination. **Compliance date: February 22, 2013**	

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F0371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation and interview, the facility failed to ensure 3 of 5 drink carts observed and 1 of 3 steam tables observed were clean during 1 of 1 meal observations and failed to ensure the dry storage floor was clean for 1 of 2 kitchen observations. Findings include: During a lunch observation in the dementia unit dining rooms, the following was observed on 1/14/2013 at 11:30 a.m. There were 20 residents in the dining room that were being served drinks from a rolling cart. The cart handles had a build up of debris and splatters and the three tiers on cart had soiling with brown substances and scattered debris. The trash can lid was soiled with debris and splatters. The drink cart in the walnut dining	F0371	**F371 Food Procure, store, prepare/serve-sanitation** It is the practice of this facility to establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** · Rolling Drink cart, trash cans/lids, floor in dry storage and Steam table were cleaned immediately. · Dietary equipment are all on cleaning schedule after each use	02/22/2013

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	room had one handle that was soiled with debris and splatters. The steam table was soiled on the bottom shelf with scattered spills and debris. There were divided plates, a tray of paper plates, and 2 trays of condiments on the bottom shelf. During an interview with the Dietary Clinician on 1/14/2013 at 12:25 p.m., she indicated the steam table and the carts were soiled. The drink cart on walnut lane had soiled handles with a build up of debris and the 3 tiers had splatters and debris. During an interview with the Dietary Manger on 1/14/2013 at 12:33 p.m., he indicated the cart was soiled. He indicated the carts were to be wiped down every day and cleaned at least every two weeks. During the initial kitchen tour on 1/14/2013 at 10:15 a.m., with the Dietary Manager the following was observed: The floor in the dry storage room was slick and your feet slid on the floor when walking on the floor. The Dietary Manger indicated the floor needed to be mopped. 3.1-21(i)(3)		**How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken** · Residents who reside in the facility have the potential to be affected by the alleged deficient practice. · Deep cleaning of Kitchen equipment and floors was completed and on a weekly schedule was put in place · Dietary Staff has been re-educated on proper cleaning of dietary equipment after each use1-30-2013 by SDC/Dietary Manager/Designee.. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur** · Dietary Staff has been re-educated on proper cleaning of dietary equipment after each use on 1-30-2013 by SDC/Dietary Manager/Designee · The Dietary Manager/Kitchen Manager will monitor cleaning schedules every shift daily.	

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			How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place · Non-compliance with facility policy and procedure may result in employee re-education, and/or disciplinary action up to and including termination. · An "Facility Environmental Review" CQI tool will be utilized weekly x 4, monthly x2 and then quarterly thereafter for at least 6 months to monitor compliance with cleaning of dietary equipment after each use and flooring. The CQI committee will review the data. If compliance of threshold of 90% is not met, an action plan will be developed. **Compliance date: February 22, 2013**	

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F0465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation and interview, the facility failed to ensure floors, cove boards and bathrooms were clean for 7 of 40 rooms observed, 2 of 4 dining rooms observed and for 2 of 2 elevators observed for cleanliness. (Room 208, 213, 212, 257, 218, 240, 202, dementia unit dining room, 2 floor dining room, elevators) Findings include: During room observations on 1/14/2013 and 1/15/2013, the following was observed: Room 208: The bathroom cove board had a build up of debris. Room 213: The cove board on the right side of toilet was loose and caved in. The caulking around the toilet was soiled. Room 212: The cove board around the room was caved in and ill fitting around the room. There was whole in the dry wall bathroom above the toilet, the top of toilet did not fit, and	F0465	**F465 Safe/Clean/Comfortable/Homelike Environment** It is the practice of this provider to ensure residents are provided with a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** · Room #208,213,212,257,218,240,202 cove base in rooms, bathrooms, hallways and dining rooms, dry wall, painted window seal, dirt build up on floors, and/or caulking have all been cleaned and repaired · Both elevator tracks have been cleaned · Memory Care and 2 nd Floor Dining rooms cove base, baseboards, thresholds and floor	02/22/2013

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	the cove board had a build up of debris. Room 257: There was a build up of debris around the cove board in the bathroom and at the entryway of the room. Room 218: There was ill fitting coveboard around the room. Room 240: There were 3 areas of chipped paint and wood in the window sill. There was a build up of debris around the cove board on the bathroom floor. Room 202: There was ill fitting cove board around the walls and cracked drywall on left side of heater unit. During the environmental tour on 1/23/2013 at 9 a.m., with the Environmental Services Director and the Maintenance Director the following was observed: The elevator outside the entry to the memory care unit entry floor grates had a build up of debris and splattered substances. The elevator on Magnolia hall floor grates had a build up of debris and splatters.		edging have been cleaned **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken** · Residents who reside in the facility have the potential to be affected by the alleged deficient practice. · Housekeeping Staff including Maintenance and Housekeeping Supervisors have been re-educated on 1-30-2013 with post test administered to evaluate the retention of education by SDC on observing dining rooms, bathrooms, rooms and elevators needing repair , cleaning, or replaced and to clean and/or complete necessary maintenance slips for repair/replacement when needed. · All rooms and bathrooms floor edging and cove base, elevators were cleaned immediately. **What measures will be put into place or what systemic changes you will make to ensure that the deficient**	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	The 2nd floor dining room wood baseboards were layered with dust and debris. There were scattered splatters on the wood wall around the dining room. There was a build up of gray and black debris around the walls at entry to the dining room and the threshold had a build up of debris. 3.1-19(f)		**practice does not recur** · Preventive Maintenance schedule will be followed to identify areas of repair and/or replacement by Maintenance and Housekeeping Departments. · Weekly cleaning schedules have been established for cove base, floor edgings and elevator grates throughout facility, weekly cleaning will be monitored by the Housekeeping Supervisor · Customer Care Representative will monitor on daily rounds and report accordingly. · Staff re-educated 1-30-2013 on completing maintenance slips when areas or items are in need of repair or replacement and proper cleaning with post test administered to evaluate the retention of education by SDC **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place** · A "Facility Environmental Review" CQI audit tool will be completed weekly x 4. Monthly x 2, and then quarterly thereafter for at least 6 months by	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155139	A. BUILDING 00 B. WING	01/24/2013

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			Housekeeping Supervisor. · The CQI committee reviews the audits and action plans are developed to ensure safe/clean environment if threshold of 90% not met. **Compliance date: February 22, 2013**	